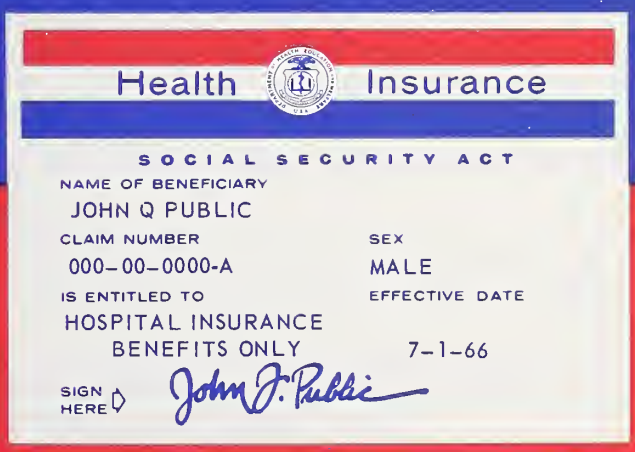
Your Medicare Handbook



HOSPITAL INSURANCE UNDER SOCIAL SECURITY

SSI-50a
January 1972

Dear Beneficiary:

This is Your Medicare Handbook. It explains the benefits you are entitled to under hospital insurance and tells how the program works.

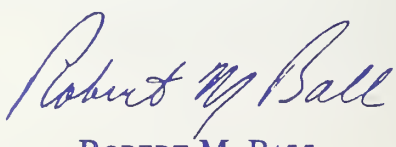
Our records show you have only the hospital insurance part of Medicare. There is also the medical insurance part of Medicare which helps pay for doctors' services and other important health care services which are not covered by your hospital insurance. How you can get medical insurance is explained on page 15.

I believe this handbook will answer most of your questions about your hospital insurance, but some details have necessarily been omitted.

Should you ever have a question about the amount of a bill Medicare helped pay, get in touch with the organization shown on your *Medicare Hospital Insurance Benefits Record.*

If you need further information or want help concerning your Medicare protection or any other social security matters, please get in touch with your social security office. The people there are always glad to help you.

Sincerely yours,

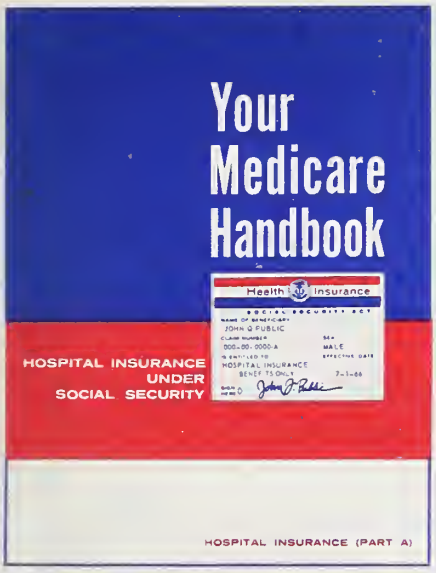


ROBERT M. BALL
Commissioner of Social Security

P.S. The cost of health care has been rising faster than other costs of living. When health care costs go up, Medicare costs more too.

You can help slow down the rise in health care costs in two ways:

1. If you know you are going to have to see a doctor about some ailment, don't put it off too long. If you wait too long, the ailment may be much harder to cure, or even impossible. And it could cost much more.
2. Don't ask your doctor to prescribe more medicine or more treatments or a longer stay in a hospital or extended care facility than he thinks you really need.



Medicare has two parts, hospital insurance and medical insurance.

Our records show you have hospital insurance only.

This handbook describes **hospital insurance,** often called **Part** A of Medicare. This is the part that helps pay for your care when you are in the hospital and for related health services, when you need them, after you leave the hospital.

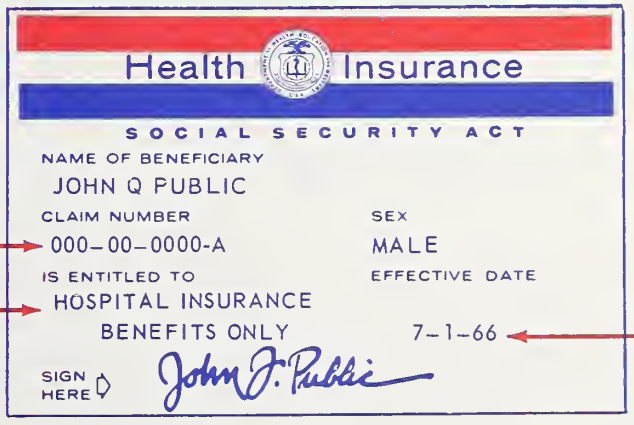
The other part of Medicare is medical insurance, often called **Part** B of Medicare. How you can get medical insurance is described on page 15.

Your Medicare health insurance card shows the protection you have

The people at the hospital or wherever you get services, can tell from your health insurance card that you have hospital insurance and when it started. This is why you should always have your card with you when you receive services.

When a husband and wife both have Medicare protection, they receive separate cards and claim numbers.

If you ever lose your health insurance card, the people in your social security office will get you a new one.



This is your personal health insurance claim number. It must be shown on all Medicare claims exactly as it is shown on your card—INCLUDING THE LETTER AT THE END.

This shows you have hospital insurance.

The date your hospital insurance starts is shown here.

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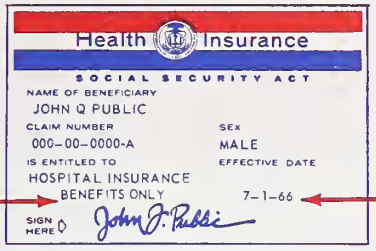

This shows that you are entitled to the benefits described in this handbook.

The date your hospital insurance starts is shown here.

HOW HOSPITAL INSURANCE WORKS

Your hospital insurance helps pay for medically necessary covered services provided by health facilities participating in Medicare when you are:

- **A BED PATIENT IN A HOSPITAL,**

And . . . if you need further care ***after*** a hospital stay, when you are:

- **A BED PATIENT IN AN EXTENDED CARE FACILITY,** or
- **A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY.**

The services hospital insurance helps pay for are called *covered services*. When you meet the conditions described on the following pages, your hospital insurance *covers almost all of the services* you would ordinarily receive as a bed patient in a participating hospital or extended care facility or as a patient at home receiving services from a participating home health agency. Your hospital insurance will also, in some cases, help pay for care in certain hospitals that do not participate in Medicare (see page 12).

When you receive covered services from a participating hospital, extended care facility, or home health agency, you do not need to make any claim for your hospital insurance benefits. These institutions or agencies make the claims and receive the Medicare payment. They have agreed to charge you only for services which are not covered by Medicare.

You will always receive a notice from the Social Security Administration when a payment has been made on your behalf.

All outpatient hospital services are covered only by medical insurance. See page 15.

Health Facilities Must Meet Certain Conditions to Take Part in Medicare

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

How Often You Can Use Your Hospital Insurance Benefits—and How Your Benefits Can Be Renewed

Your use of hospital insurance benefits is limited to certain *maximum* amounts for certain periods of time—but there is a way for your hospital insurance benefits to *start over again* (except the "lifetime reserve" described on page 8.) You can figure out yourself how this works:

HOW THE USE OF HOSPITAL INSURANCE BENEFITS IS COUNTED

WHEN YOU RECEIVE COVERED SERVICES AS—	YOUR PART A BENEFITS ARE—
• A bed patient in a hospital.	• Up to 90 "hospital days" for each "benefit period."
• A bed patient in an extended care facility.	• Up to 100 "extended care days" for each "benefit period."
• A patient at home receiving home health services.	• Up to 100 "home health visits" for each "benefit period." (Page 11 describes the 1-year time limit on these visits.)

These three kinds of benefits and how you qualify for them are described in more detail on the following pages. But, as you can see, you can get covered services for up to these total numbers of "days" and "visits" for *each* "benefit period." So you need to know what a "benefit period" is to know how often you can use your hospital insurance benefits.

WHAT IS A "BENEFIT PERIOD"?

A "benefit period" is simply a period of time for measuring your use of hospital insurance benefits. (In the first Medicare Handbook and in some other Medicare publications, we called this period of time a "spell of illness," which is the term used in the law. But because many people thought this term had something to do with a single illness or a particular "spell" of sickness, we are now calling it a "benefit period.") This is how it works.

The first time you enter a hospital after your hospital insurance starts will be the beginning of your *first* benefit period. Your first benefit period *ends* as soon as you have not been a bed patient in any hospital (or any facility that mainly provides skilled nursing care) for *60 days in a row*. After that, a *new* benefit period begins the next time you enter a hospital—and *that* benefit period ends as soon as you have *another* 60 days in a row when you are not a bed patient in any hospital (or any facility that mainly provides skilled nursing care). Then *another* benefit period can begin the *next* time you enter a hospital—and so on.

There is no limit to the number of benefit periods you may have. There is an easy way to remember the rule. Just keep in mind that *any time* you are not in any hospital or other facility mainly providing skilled nursing care for *60* days in a row a *new* benefit period will begin the next time you go into a hospital. And, of course, for each new benefit period, your full hospital insurance benefits are available again to use as you need them.

You Get a Personal Record of Benefits Used

You don't have to bother about trying to keep track of how many "days" or "visits" you use in each benefit period. The notice you receive from the Social Security Administration after you have used any hospital insurance benefits will tell you how many benefit "days" and "visits" you have left in that benefit period. But, very few people who enter a hospital or extended care facility, or use home health services, need these services long enough to use all the benefits they have for a benefit period. So most people will never run out of "days" or "visits," because a new benefit period will almost always start with full benefits available again the next time they are needed.

EXAMPLE:

Mr. L was in the hospital for 14 days and then went home.

After being at home for 80 days, Mr. L needs to return to the hospital. When Mr. L is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital (or other facility that mainly provides skilled nursing care). The benefit days Mr. L used the time before do not matter because he is in a new benefit period.

However, because Mr. L had been in the hospital only 14 days, he still had 76 hospital benefit days left in the original benefit period. If he had had to go back to the hospital within 60 days, instead of 80, he could have used any of these remaining days that he needed during this second stay.

How Hospital Insurance Benefits Are Financed

The hospital insurance program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected along with regular social security contributions from the wages and self-employment income earned during a person's working years.

The contribution rate for the hospital insurance program is six-tenths of one percent of the first $9,000 of earnings. It will increase gradually until 1987 when it will reach the final rate of nine-tenths of one percent.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid. Funds from general tax revenues are used to finance hospital insurance benefits for people who are covered under the program but are not entitled to monthly social security or railroad retirement benefits.

In addition, the law provides that the various dollar amounts for which the patient is responsible be reviewed annually. These dollar amounts include the first $68 of hospital charges in each benefit period and different per-day amounts after certain periods of benefit use in hospitals and extended care facilities. These are described on the following pages. The law also provides that if this annual review shows that hospital costs have changed significantly these amounts must be adjusted for the following year.

What Hospital Insurance Can Pay When You Are a Hospital Bed Patient

In *each* benefit period, your hospital insurance can help pay for *up to 90* days of bed patient care in any participating general care, tuberculosis, or psychiatric hospital.

- For the first 60 days—hospital insurance pays for all covered services, *except for the first $68.*
- For the 61st through the 90th day—hospital insurance pays for all covered services, *except for $17 a day.*

IMPORTANT!

Once you have taken care of the ***first*** **$68** of hospital expenses in each benefit period, ***you do not have to pay it again,*** even if you have to go back in a hospital more than once in that same benefit period.

Also, You Have a "Lifetime Reserve" of 60 Additional Hospital Days

This is like a "bank account" of extra days to draw from if you need them. You can use them if you ever need more than 90 days of hospital care in the same benefit period. For each "lifetime reserve" day used, hospital insurance pays for all covered services, *except for $34 a day.*

Each lifetime reserve day you use permanently reduces the total you have left.

Usually you will want to use your lifetime reserve days if you need hospital care after you have used all your 90 days in a benefit period. *Unless* you decide *not* to use them, the extra days of hospital care that you use are automatically taken from your lifetime reserve.

If for any reason you do not wish to use your reserve days, the hospital will ask you to say so in writing. In making your decision, you should consider any private insurance you have which may pay for some or all of your additional hospital care. And, of course, you may wish to talk to your doctor or the people at the hospital about whether in your particular situation you should draw on your lifetime reserve.

EXAMPLE: Mrs. S had to go to the hospital a number of times in the same benefit period and used up all her 90 days. Before a new benefit period could start she again needed to go to a hospital. She can draw from her "lifetime reserve" days to help her pay for the hospital care.

Special Rules for Benefits in Psychiatric Hospitals

For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days. Also, for a beneficiary who is a patient in a psychiatric hospital on the day his hospital insurance starts, there is a special limitation which is described in Question 5 on page 13.

Your Benefits When You Are a Bed Patient in a Participating Hospital

The list below describes the kinds of benefits that hospital insurance will help pay for when you are a bed patient in a hospital and some of the services that it cannot pay for.

Part A Helps Pay For:

- Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
- Operating room charges.
- Regular nursing services (including intensive care nursing).
- Drugs furnished by the hospital.
- Laboratory tests.
- X-ray and other radiology services.
- Medical supplies such as splints and casts.
- Use of appliances and equipment furnished by the hospital such as a wheelchair, crutches, and braces.
- Medical social services.

Part A Does NOT Pay For:

- Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
- Private duty nurses.
- Any extra charge for use of a private room, unless you need it for medical reasons.
- Noncovered levels of care.
- Doctors' services (medical insurance helps pay for these).

An Example of How Hospital Insurance Helps Pay for Hospital Care

Mrs. C was in the hospital for 14 days.

During her stay in the hospital, Mrs. C had an operation. Her bill included the hospital charges for semiprivate room and all meals, including special diet; use of the operating room; X-rays, laboratory tests; oxygen; and drugs furnished by the hospital. There was also a charge of $9.25 for television and telephone services.

Of the total hospital bill of $798.25, Mrs. C paid $77.25. (This was the first $68 for that benefit period plus the charges for the television and telephone.) Her hospital insurance took care of the remaining $721.

Extended Care Benefits After You Leave the Hospital

Sometimes a patient no longer needs all the care which hospitals provide, but still needs full-time skilled nursing care and other health services which cannot be furnished in his home. In these cases, the doctor may transfer the patient from the hospital to an extended care facility. This is a specially qualified facility which is staffed and equipped to furnish full-time skilled nursing care and many important related health services.

Hospital insurance pays for all covered services in a participating extended care facility for the first 20 days you receive such services in each benefit period and all but $8.50 a day for up to 80 more days in that same benefit period, *but only if all the following are true:*

1. Your medical needs require continuing skilled nursing care;
2. A doctor determines that you need extended care and orders such care for you;
3. You have been in a participating (or otherwise qualified) hospital for at least 3 days in a row before your admission;
4. You are admitted within 14 days after you leave the hospital; and
5. You are admitted for further treatment of a condition for which you were treated in the hospital.

If you leave an extended care facility and are readmitted to one within 14 days, you can continue to use your additional extended care benefit days for that benefit period without a new 3-day stay in a hospital.

The following list describes some of the kinds of extended care services hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:

- Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
- Regular nursing services.
- Drugs furnished by the extended care facility.
- Physical, occupational, and speech therapy.
- Medical supplies such as splints and casts.
- Use of appliances and equipment furnished by the facility such as a wheelchair, crutches, and braces.
- Medical social services.

Part A Does NOT Pay For:

- Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
- Private duty nurses.
- Any extra charge for use of a private room, unless you need it for medical reasons.
- Noncovered levels of care.
- Doctors' services (medical insurance helps pay for these).

Home Health Benefits After You Leave the Hospital

After you have been in a hospital (or in an extended care facility *after* a hospital stay), your doctor may decide that the continued care you need can best be given in your own home through a home health agency. If the continuing care you need in your home includes part-time skilled nursing care or physical or speech therapy, Medicare can pay for this care and also for certain additional health care services you may need.

Hospital insurance pays for all covered services—for as many as 100 home health visits after the start of one benefit period and before the start of another.

The visits must be medically necessary and be furnished by a participating home health agency. Benefits can be paid for up to a year after your most recent discharge from a hospital or participating extended care facility *but only if all the following are true:*

1. You were in a participating (or otherwise qualified) hospital for at least 3 days in a row;
2. The continuing care you need includes part-time skilled nursing care or physical or speech therapy;
3. You are confined to your home;
4. A doctor determines that you need home health care and sets up a home health plan for you within 14 days after your discharge from the hospital or a participating extended care facility; and
5. The home health care is for further treatment of a condition for which you received services as a bed patient in the hospital or extended care facility.

For an explanation of how "visits" are counted, see Question 8 on page 13.

The following list describes the kinds of home health services that hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:

- Part-time nursing care, physical therapy, or speech therapy.
- And if you need any of the above services, the following services are also covered:
  - Occupational therapy.
  - Part-time services of home health aides.
  - Medical social services.
  - Medical supplies and appliances furnished by the agency.

Part A Does NOT Pay For:

- Full-time nursing care.
- Drugs and biologicals.
- Personal comfort or convenience items.
- Noncovered levels of care.
- Meals delivered to your home.

Benefits for Care in Hospitals That Do Not Take Part in Medicare

Nearly all hospitals in the country take part in Medicare. But if you are admitted for emergency care to a hospital that does not take part in Medicare, hospital insurance may still be able to help pay some of the bills.

Your hospital insurance can help pay for emergency care if the hospital: (1) meets certain conditions listed in the law; (2) is the closest or the quickest one to get to that has a bed available; and (3) is equipped to handle the emergency.

If you receive emergency care in such a hospital, the benefit payment will usually be made to the hospital. If the hospital decides to bill you instead of Medicare, the benefit payment will be made to you. The people at your social security office will help you make your claim.

Utilization Review

Each hospital and extended care facility has a Utilization Review Committee. The purpose of this committee is to help assure the most effective utilization of hospital or extended care facility services. The committee, which includes at least two physicians, reviews admissions on a sample basis and reviews ALL long-stay cases.

In some cases, the review will show that a patient's stay in the hospital or the extended care facility is no longer medically necessary. For a hospital inpatient, the review could indicate that a different kind of care would be more appropriate, for example, care in an extended care facility which Medicare could help pay for. For the patient in the extended care facility, the review might show that the patient was no longer receiving the kind of care for which Medicare could pay extended care benefits.

When this happens, the committee talks the matter over with the patient's doctor and then makes a decision. If the decision is that the patient can receive the kind of care he needs elsewhere, the patient, his doctor, and the hospital or extended care facility are advised in writing.

Three days after this notice, Medicare, by law, has to stop paying inpatient benefits even if the patient stays in the facility.

Questions and Answers About Hospital Insurance

1. ***Where can I find out if a hospital, extended care facility, or home health agency is participating in Medicare?***

   Your doctor, or someone at the institution or agency, can tell you. Or you can ask the people in any social security office.

2. ***If I am injured while at work and my medical expenses are (or could be) covered by the workmen's compensation law, will my hospital insurance also pay?***

   No.

3. ***Does hospital insurance pay for services in a foreign hospital?***

   No, but there is one exception: if (1)

Questions and Answers About Hospital Insurance (continued)

you are in the United States when an emergency arises and (2) the foreign hospital is closer than the nearest hospital in the United States which could provide the emergency care you need, then hospital insurance will help pay for the emergency care.

4. ***Can hospital insurance pay anything toward the cost of my care in a Christian Science sanatorium?***

Yes. Your hospital insurance can cover certain hospital and extended care services furnished to inpatients of a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston. For more information, ask at any social security office.

5. ***Is there a special rule for beneficiaries who are in a psychiatric hospital when their hospital insurance protection starts?***

Yes. When a person is a patient in a psychiatric hospital *at the time* his hospital insurance starts, the days in the mental hospital during the 150-day period just before his hospital insurance starts count against the total number of benefit days he can use in a psychiatric hospital in his first benefit period.

These days, however, do not count against his lifetime maximum of 190 days of payment for care as a patient in a psychiatric hospital. Nor do they count against his benefit days in his first benefit period if he goes to a *general hospital* for treatment of a condition other than mental illness. (For more information, get in touch with your social security office.)

6. ***What can I do if I think a mistake has been made in the amount of my hospital insurance benefits?***

The first thing to do is to ask someone at the hospital, extended care facility, or home health agency that provided the services. Usually they can answer your questions. Sometimes, however, they may need to refer you to the organization that handles their Medicare payments. If you are still not satisfied, get in touch with your social security office for information about your right to formal appeal.

7. ***What if I cannot pay the amounts that hospital insurance does not pay?***

You may want to ask at your local public assistance office about help under a State program such as old-age assistance or medical assistance (sometimes called "medicaid").

8. ***What is a home health "visit"?***

One "visit" is counted *each* time you receive a covered health care service from a home health agency. If you receive two *different* services on the same day (for example, both a nurse and a physical therapist call on you), that would be *two* "visits." It would also be two "visits" if you received the *same* service twice in a day (such as two calls by a nurse).

Some Health Services and Items That NEITHER Hospital Insurance Nor Medical Insurance Will Pay For

Under each kind of benefit described in this handbook, there is a list of items and services hospital insurance will not pay for. There are also some other items or services that are not covered under either part of Medicare. These are shown in the following list:

- Services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Cosmetic surgery—*except when furnished in connection with prompt repair of accidental injury or for the improvement of the functioning of a malformed body member.*
- Services for which neither the patient nor another party on his behalf has a legal obligation to pay—*such as free chest X-ray.*
- Certain services payable under other Federal, State, or local government programs.
- Services furnished by immediate relatives or members of the patient's household.

The First 3 Pints of Blood

Hospital insurance cannot pay for the first 3 pints of whole blood (or units of packed red blood cells) you receive in a *benefit period.* Usually when you receive blood under hospital insurance, it will be as a bed patient in a hospital. The blood you receive under hospital insurance is fully paid for beginning with the fourth pint you get during a benefit period.

HOW TO GET HELP TO REPLACE BLOOD

Some people are able to arrange for the replacement of these first 3 pints of blood—that way they don't have to pay for them. There are two ways this can be done. First, *you* may arrange for replacement from a friend or relative or you may be a member of a blood donor group that will replace these first 3 pints of blood for you. Second—and this is often overlooked—your children (or your son-in-law or daughter-in-law) may belong to a blood replacement plan that includes you as a beneficiary. In that case, you would be eligible for blood on the basis of *their* membership.

You might want to check with your children and children-in-law about this so you'll have the information handy if you ever need it.

In almost all blood donor plans, blood replacement credit can be arranged anywhere in the United States.

If You Want to Sign Up for Medical Insurance

Your Medicare protection is limited to the hospital insurance benefits described in this handbook because you have not signed up for medical insurance.

Medical insurance can give you important additional protection because it helps pay for doctor's services and for many other services and supplies not covered by your hospital insurance. In addition, it helps pay for home health benefits even if you have not been in a hospital. Outpatient hospital services are covered only by medical insurance.

The basic medical insurance premium for each person is $5.60 a month through June 1972. It will be increased to $5.80 for the 12-month period starting in July 1972. Those who delayed signing up for a long period of time after their first chance or who signed up again after canceling this insurance in the past are required by law to pay an additional 10 percent for each full year they were eligible but not enrolled. Starting in July 1972, the premium will be $6.40 a month for those who did not enroll for a year or longer after they were eligible, $7.00 a month for those who delayed 2 years or longer, and $7.50 for those who delayed 3 years or longer.

HERE IS HOW YOU CAN GET THE ADDITIONAL PROTECTION OF MEDICAL INSURANCE

If less than 3 months have passed since the month you were 65, you are still in your first sign-up period, and you can sign up now. But don't delay—your first sign-up period ends 3 months after the month you reach 65.

If more than 3 months have passed since the month you were 65, you can sign up during a general enrollment period (January, February, and March of each year) which starts within 3 years from the end of your first sign-up period. If you do not sign up during one of these enrollment periods, you cannot sign up at all.

If you once had medical insurance but dropped it, you will be able to sign up one more time, but only during a general enrollment period (January, February, or March) which starts within 3 years after your protection stopped.

WHEN YOUR MEDICAL INSURANCE CAN START

If you sign up in any of the 3 months *before* you reach 65, your medical insurance will start on the first day of the month you reach 65. But if you delay and sign up *in* the month you reach 65 or in any of the 3 months after that month, your protection will start 1 to 3 months **after** you sign up.

If you wait to sign up in a general enrollment period or if you are signing up again after dropping out, your protection will start the following July 1.

YOUR MEDICAL INSURANCE PREMIUM

If you sign up for medical insurance and are receiving social security or railroad retirement benefits or a civil service annuity, your premium would be deducted from your check each month, beginning the month your protection starts.

If you are not receiving benefit checks, you would be sent a bill for your premium each 3 months.

When you sign up for medical insurance, you do not have to continue it. You can give notice at any time that you intend to drop it, and it will stop at the end of the next calendar quarter.

If you want more information about signing up for medical insurance, get in touch with your social security office. The people there will be glad to help you.

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